



STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

Medical Facilities Unit – Acute Care
Hospice Program

SECTION 1: Agency Information			
Agency Name:			
Doing Business As:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ()		Fax No.: ()	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR HOSPICE PROGRAM	
License Type: <input type="checkbox"/> Initial Application (fee \$200) <input type="checkbox"/> Renewal Application (fee \$200) License Renewal Period (dates): _____ to _____	\$ _____ \$ _____
Make checks or money orders payable to “Treasurer, State of Maine”. Do not send Cash. Credit Cards are not accepted at this time.	
Total Checks/Money Orders enclosed =	\$ _____

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Regulatory Services
Medical Facilities – Acute Care Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: DLRS.MedFacilities@maine.gov

Office Use Only: Check# _____ MO # _____ Amount \$ _____ Initials: _____ License# _____

SECTION 3: Ownership Information (Use additional sheets, if necessary)**Type of Entity:**☐ Sole Proprietorship (complete section A)☐ Corporation (complete section C)☐ Partnership (complete section B)☐ Not-for-Profit (complete section D)☐ Other: _____**A. Sole Proprietorship**

Owner Name:

Mailing Address:

City:

State:

Zip:

County:

Telephone No.: ()

ID# (Owner SSN or EIN#):

B. Partnership

List the names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

Name

Address

_____	_____
_____	_____
_____	_____
_____	_____

C. Corporation

List the names, address and titles of the Officers and Directors.

Officer Name

Title

Address

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Director Name

Title

Address

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Not-for-Profit

List the name and address of the President of the Board of Directors or the appropriate Municipal Government Representative.

Name

Address

SECTION 4: Facility Information (Use additional sheets, if necessary)

Name of Person in Charge:

Title:

Home Address:

City:

State:

Zip:

County:

Home Telephone No.: ()

Office Telephone No.: ()

Hospice Program Operation Date:

Date that this program has been open since: _____

Date that this program is scheduled to open: _____

Geographic area served: _____

Location of all multiple locations utilized by the Hospice Program Provider:

Name of Owner of Building
Telephone Number

Address

1. _____

2. _____

3. _____

Services Provided: Please select all that apply and indicate when each service was started.

- | | |
|--|---|
| <input type="checkbox"/> Nursing Services _____ | <input type="checkbox"/> Physical Therapy Services _____ |
| <input type="checkbox"/> Medical Social Services _____ | <input type="checkbox"/> Occupational Therapy Services _____ |
| <input type="checkbox"/> Physician Services _____ | <input type="checkbox"/> Speech/Language Therapy Services _____ |
| <input type="checkbox"/> Counseling Services _____ | <input type="checkbox"/> Home Health Aides & Homemaker Services _____ |
| <input type="checkbox"/> Volunteer Services _____ | <input type="checkbox"/> Other: _____ |

Levels of Care Provided: Please select all that apply and indicate when each service was started.

- | | |
|---|--|
| <input type="checkbox"/> Routine Home Care _____ | <input type="checkbox"/> Continuous Care _____ |
| <input type="checkbox"/> Respite Care _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> General Inpatient Care _____ | |

Accreditation: Please select all Accreditation Organizations that this Hospice Program is accredited by.

☐ Joint Commission ☐ CHAPS ☐ Other: _____

☐ Federal Deemed Status Dates: _____

Full-Time Equivalent Staff: All employees of the Hospice Program Provider, including administrative, business, clerical and direct service providers, must be included in the calculation of this figure. A full-time equivalent employee is one or more individuals who is/are employed on the basis of at least 37 ½ hours per week for the hospice agency. Both individuals directly employed and those contracted by the agency shall be counted in the calculation of the agency's full-time equivalency figure.

How many full-time equivalent staff are employed by the agency? _____

Directions to the Agency: Please be specific, draw/provide a map if possible.

SECTION 5: Submission

Submit your completed application with the following:

- A check or money order made payable to "Treasurer, State of Maine"
- A copy of any and all leases, if the building(s) used is leased.
- Letter(s) from the appropriate Municipal Official(s) that demonstrates compliance with all Local Ordinances relative to zoning and building code regulations. Applicable for Initial applicants or if you have moved since your last renewal.

SECTION 6: Declaration

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, being duly authorized to assume responsibility for the conduct of the agency herein described, do hereby apply for a license to operate the agency and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA Chapter 1681, Sections 8621-8631.

Print name of Administrator

Signature of Administrator

Date